

APPENDIX A : NYG Form 6130.1 Report of Medical Examination

MEDICAL RECORD	NEW YORK GUARD REPORT OF MEDICAL EXAMINATION	DATE OF EXAM:
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NOTE: This information is for official and medically confidential use only and WILL NOT be released to unauthorized persons

1. NAME OF PATIENT (Last, first, middle)		2. NYG ID NUMBER	3. GRADE
4a. HOME ADDRESS (Street or RFD; City or Town; State and ZIP code)		5. EMERGENCY CONTACT (Name and Address)	
4b. CITY	4c. STATE	4d. ZIP CODE	
6. DATE OF BIRTH	7. AGE	8. SEX ___ FEMALE ___ MALE	9. RELATIONSHIP OF CONTACT
10. PLACE OF BIRTH	11. RACE ___ WHITE ___ BLACK ___ ALASKAN NATIVE ___ AMERICAN INDIAN/ HISPANIC ___ HISPANIC ASIAN/PACIFIC ___ ISLANDER		

CLINICAL EVALUATION

NOR-MAL	17. Check each item in appropriate column, enter "NE" if not evaluated	ABNOR-MAL	18. Describe every abnormality in detail. Enter pertinent item letter before each comment	19. Summary of Defects and Diagnosis. Enter item letter before each comment
	A. HEAD, FACE, NECK & SCALP			
	B. EARS-General (Internal Canals)			
	C. DRUMS (Perforation)			
	D. NOSE			
	E. SINUSES			
	F. MOUTH AND THROAT			
	G. EYES-General			
	H. PUPILS (Equality & Reaction)			
	I. OCULAR MOBILITY (Associated parallel movements nystagmus)			
	J. LUNGS & CHEST (Incl Breasts)			
	K. HEART (thrust,size,rhythm,sounds)			
	L. VASCULAR SYSTEM (varicostis, etc)			
	M. ABDOMEN & VISCERA (incl Hernia)			
	N. ENDOCRINE SYSTEM			
	O. UPPER EXTREMITIES (strength, range of motion)			
	P. FEET			
	Q. LOWER EXTREMITIES (strength, range of motion)			
	R. SPINE, other Musculoskeletal			
	S. IDENTIFYING BODY MARKS, Scars, Tatoos			
	T. SKIN, Lymphatics			
	U. NEUROLOGIC (muscle strength, equilibrium)			
	V. PSYCHIATRIC			

MEASUREMENTS AND OTHER FINDINGS

20. HEIGHT	21. WEIGHT	22. COLOR HAIR	23. COLOR EYES	24. BUILD: ___ SLENDER ___ MEDIUM ___ HEAVY ___ OBESE	25. BLOOD TYPE
26. BLOOD PRESSURE (Arm at Heart Level)			27. DISTANT VISION		
A. SITTING	SYS DIAS	B. RECUMBANT	SYS DIAS	RIGHT 20/ LEFT 20/	CORRECTED TO 20/ CORRECTED TO 20/
28. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify, Reference Item Number)					

29. EXAMINEE IS (check)	<input type="checkbox"/> QUALIFIED FOR	<input type="checkbox"/> ENLISTMENT / RE-ENLISTMENT
	<input type="checkbox"/> NOT QUALIFIED FOR	<input type="checkbox"/> PERIODICAL / RETENTION
30. IF NOT QUALIFIED LIST DISQUALIFYING DEFECTS BY ITEM NUMBER:		
31a. TYPED OR PRINTED NAME OF EXAMINER	31b. SIGNATURE	31c. DATE

NYG FORM 6130.1 (Replaces NYG Form 88 which is obsolete)

Version date: 24 Sept 2010 Previous versions obsolete Check here if Continuation Sheet is used and enter number of sheets ___

Print Examiner Medical License Number **A-1**
and Office Address:

NEW YORK GUARD REPORT OF MEDICAL EXAMINATION

CONTINUATION SHEET

CONTINUATION SHEET NUMBER ____ of ____

MEDICAL RECORD

DATE OF EXAM

DD MM YYYY.

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1. NAME (Last, First, Middle)

2. NYG ID NUMBER

3. GRADE

Include item number(s) from NYG Form 6130.1, Report of Medical Examination,
and enter additional information below